Virginia Medicaid
DOSE OPTIMIZATION
Prior Authorization Request Form

The intent of this initiative is to use the optimum dose of a product to fill a prescription. An example of this is to use one 10 mg Abilify tablet instead of two 5mg Abilify tablets to fill a prescription. If the quantity submitted on the claim is over 34 units for a 34-day supply then the claims will reject with an error message of "DOSE OPT LMT 34/MO–MD 800-932-6648". In order for patients to receive more than a 34-day supply for these drugs, it will be necessary for the prescriber to complete and fax or mail this prior authorization request to First Health Services Corporation. The fax number and address are listed at the bottom of this form. Please complete this form in its entirety, sign, and date below. Incomplete requests will be returned for additional information.

Below is the full list of medications restricted to 34 units per month

Brand Name	Generic Name	Limitations
Abilify® 5mg, 10mg, 15mg	Aripiprazole	1 tablet / daily
Concerta® 18mg, 36 mg	Methylphenidate	1 tablet / daily
Risperdal® 0.25mg, 0.5mg, 1mg, 2mg	Risperidone	1 tablet / daily
Strattera® 10mg, 18mg	Atomoxetine	1 tablet / daily
Zyprexa® 2.5mg, 5mg,10mg	Olanzapine	1 tablet / daily

Use this form to request prior authorization for medications that are part of the Dose Optimization initiative

Prescribing physician:
Name:_____
Phone #: _____
Fax #: _____

Patient:
Name: _____
Medicaid ID #:_____
Date of Birth:_____ Sex: _____

Pharmacy (if known):_____ **Phone:** _____ **&/or FAX:** _____

Drug Requested: _____ **Strength & Frequency:**_____ **Length of therapy:** ____

Please answer the following questions, as applicable, to obtain an approval for a PA:

1. Has the patient tried less frequent dosing but was not able to tolerate due to adverse effects?
   If so, list the dose attempted and the failure._____

2. Does the patient dose require a quantity greater than 34 and this is the only way for the patient to get the prescribed daily dose? (i.e., Abilify 4 mg daily – would need 2 mg x 2).
   Please list the dose _____

3. The patient has a specific indication that requires higher than normal dosing.
   Please list the specific indications _____

4. Does the patient require 1 and ½ tablets (instead of using 2 different strengths)? Yes or No
   _____

5. Is the patient dose in the process of being titrated? If so, please give the timeframe that the titration is expected to last. _____

6. Is the patient receiving Risperdal® for Schizophrenia? If so, please indicate.

_____

7. Please indicate other reason(s) why a PA is requested.

_____

_____

_____

Comments:

Prescriber Signature:_____ Date of this request:_____

FOR FIRST HEALTH USE

Comments: _____

Approved Changed Denied Pending

MAP RPh/tech: _____

NDC: _____

Date of Decisions: _____

Submit requests via phone, fax or mail to:

First Health Services Corp.
MAP Department
4300 Cox Road
Glen Allen, VA 23060

Tel: 1-800-932-6648
FAX: 1-800-932-6651